

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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May-June 2000

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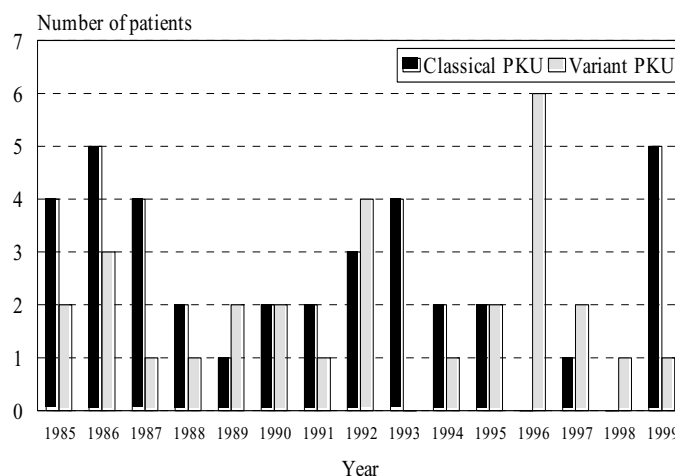
PKU in Louisiana

Sixty-six (.0062%) of 1,061,909 newborns born in Louisiana between January 1, 1985 and December 31, 1999 were diagnosed with either classical PKU (phenylketonuria) or variant PKU (Figure 1). One patient was diagnosed with 6-pyruvoyl tetrahydropterin synthase (6-PTS) deficiency, a non-PAH form of hyperphenylalaninemia. Thirty-seven of the 66 PKU patients were diagnosed with classical PKU, an incidence of classical PKU in Louisiana of 1:28,700 live births. Of the 66 PKU patients born in Louisiana, 60 (91%) were white, and six (9%) were non-white (Figure 2). Five of the non-white patients were African-American, and one had a mixed racial background (white and African-American). The frequency for PKU in the white population of Louisiana was 1:10,101, and the frequency in the non-white population was 1:75,978. Region 4, which is located in the Acadiana area of Louisiana, had the highest incidence of classical PKU with a frequency of 1:13,283 (10 cases), as well as the highest frequency for classical PKU in the white population (1:10,650 (8 cases)).

The classical and variant forms of phenylketonuria are caused by a deficiency of the liver enzyme phenylalanine hydroxylase (PAH). Extraordinarily rare forms of hyperphenylalaninemia with normal PAH activity have been described, such as those with deficiency of tetrahydrobiopterin, a cofactor for PAH. In the hyperphenylalaninemias, phenylalanine (PHE) accumulates within the blood of affected patients due to deficient activity of the PAH enzyme. Patients require strict adherence to a PHE-restricted diet in order to avoid the characteristic mental retardation seen in untreated patients.

Newborn screening and follow-up for PKU has been a mandated service performed by the Office of Public Health for over

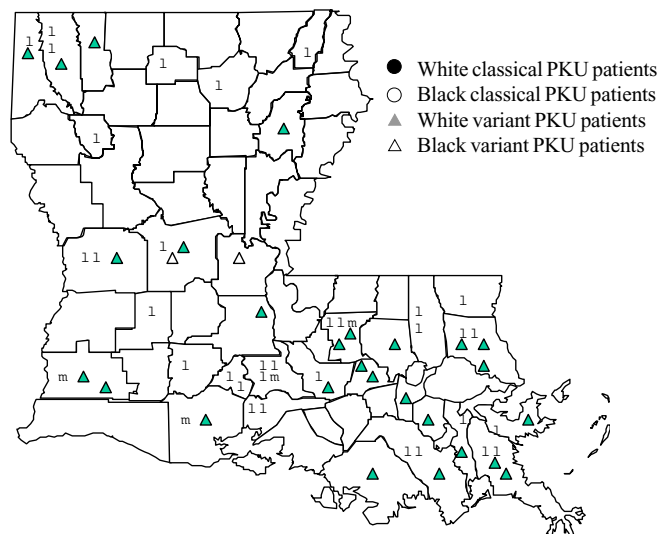
Figure 1: Patients with classical and variant PKU in Louisiana, 1985-1999



three decades. All newborns detected by the Louisiana State Genetics Newborn Screening Program with phenylketonuria (elevated plasma PHE > 120-240 μ M or 2.0-4.0 mg/dL) have been referred to the Tulane Hayward Genetics Center for confirmatory plasma amino acid analysis (quantitative HPLC) and subsequent care.

Twenty-three (85%) of the Louisiana patients in grades kindergarten through 12 are in the expected grade level and are performing satisfactorily, documenting the efficacy of the Louisiana Newborn Screening Program for PKU detection and its treatment regimen. For further information, call the Louisiana Genetic Diseases Program at (504) 568-5070.

Figure 2: Classical and variant PKU patients by race in Louisiana, 1985-1999



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Influenza 1999 - 2000 Season

Influenza outbreaks occur primarily during the winter months every year, and are responsible for significant morbidity and mortality. In its epidemic form, influenza causes thousands of deaths each year, mostly among the elderly. In 1998, 20,000 people died in the United States as a result of influenza, including 17 in Louisiana. The Immunization Program annually monitors influenza virus activity, to detect and confirm the presence, as well as the type, of influenza that may be circulating in the state. The tracking of influenza activity throughout the state is monitored by more than 25 physicians and private practices, 16 hospitals, 17 schools, 5 nursing homes, and 3 Virology Labs (Childrens Hospital, Louisiana State University Medical Center-Shreveport, and the Office of Public Health Division of Laboratory), all of which are participating voluntarily in this active surveillance program.

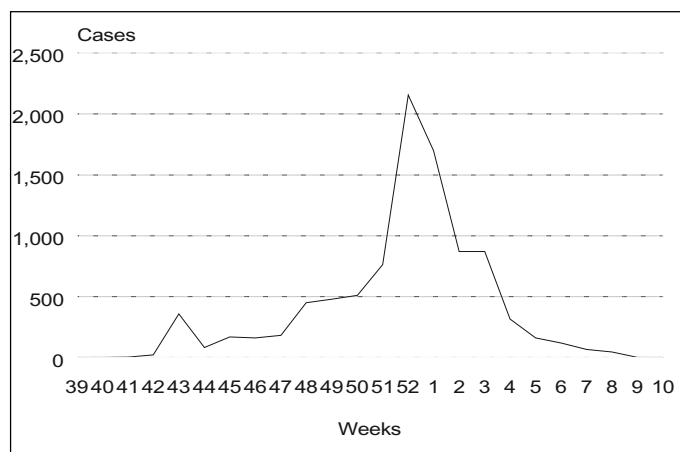
Laboratory tests to confirm influenza are performed by either the Louisiana State Laboratory, or other laboratories from specimens obtained from the participating physicians and hospitals. Normally, sporadic cases of influenza occur during the summer, yet summertime outbreaks are rare. This past year, Louisiana experienced its first summertime outbreak at an adult health care center in Baton Rouge from June 28 through July 7 (see the Louisiana Morbidity Report, September-October 1999 issue). This outbreak affected 27 individuals at a nursing home, with ages ranging from 53 years of age to 94 years. Viruses isolated were most closely related to Influenza A. Although the nursing home had an influenza vaccination campaign the previous year, the outbreak probably does not represent vaccine failure. Protection conferred by the previous season's vaccine most likely would have waned by the time of this outbreak.

Active surveillance did not detect any other outbreaks of influenza-like illness during August or September 1999, but by October, weekly surveillance detected regional flu outbreaks. By the last week of December the estimated level of influenza activity had reached widespread outbreak thresholds. During the whole 1999-2000 influenza season, the State received reports of 9,333 cases of flu or flu-like illnesses (Figure). Laboratory tests for the same period confirmed 252 cases, all of which were Type A/Sydney (H3N2). After reaching its maximum peak of cases, the flu epidemic began to decline. By the week of February 26 of this year, there were no suspected cases or cases being reported.

This 1999-00 flu season was characterized by an early seasonal onset and sharp case decline following its peak week with only Type A/ Sydney or Sydney-like strain being identified. The trivalent influenza vaccine utilized for the 1999-2000 season included: A/Beijing/262/95-like (H1N1), A/Sydney/5/97-like (H3N2), and B/Yamanashi/166/98.

For information or questions, please call the Immunization Program at (504) 483-1900.

Figure: Reported cases of either influenza or influenza-like illnesses in Louisiana, 1999-2000



NOTICE FOR THE 2000-2001 INFLUENZA SEASON

- New recommendations by ACIP call for lowering the age for routine influenza vaccine to 50 years and older (previously 65 years and older).
- The trivalent vaccine for the 2000-2001 season will consist of: A/Panama (H3N2), A/New Caledonia (H1N1-like) and B/Yamanashi.
- A *Prevention and Control of Influenza* MMWR publication was published April 14, 2000.
- Influenza vaccine manufacturers are projecting production delays similar to last year. Some vaccine orders may not get filled until late November.

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Emerging Pathogens Surveillance

Louisiana's emerging pathogens surveillance system was implemented in 1996 to track drug-resistance to *Streptococcus pneumoniae*, *Staphylococcus aureus*, and *Enterococcus* species. The protocol for drug-resistance surveillance was modified on January 1, 2000 to enhance the accuracy of the surveillance system; the new criteria requires the reporting of all isolates grown in the laboratory. Table 1 illustrates cumulative laboratory data for the number of isolates reported by the sentinel hospitals in the first quarter of 2000. The penicillin resistance seen in *S. pneumoniae* (DRSP) ranges from 22% (intermediate) to 24% (total resistance) and methicillin resistance in *S. aureus* (MRSA) is approaching 40%. The resistance rate of *Enterococcus* reported with no speciation is 7%. Vancomycin resistant *Enterococcus*, which has been speciated into *E. faecalis* and *E. faecium*, have resistance rates of 1% and 38%, respectively. These numbers are consistent with previous data collected for this surveillance system over the past two years. However, the resistance rates of MRSA, DRSP, and VRE in Louisiana are significantly higher than national rates reported by CDC.

Emerging Pathogens Surveillance Aggregate Laboratory Data January-March, 2000			
	Total # of Isolates	Resistant # of Isolates	% Resistance
<i>Streptococcus pneumoniae</i> (DRSP)	484		
Penicillin intermediately resistant		107	22%
Resistant to penicillin		116	24%
<i>Staphylococcus aureus</i> (MRSA)	2912		
Methicillin resistant		1089	37%
<i>Enterococcus species</i> (VRE)	207		
Vancomycin resistant		15	7%
<i>Enterococcus faecalis</i>	1902		
Vancomycin intermediately resistant		1	0%
Vancomycin resistant		26	1%
<i>Enterococcus faecium</i>	215		
Vancomycin intermediately resistant		2	1%
Vancomycin resistant		81	38%

*Data represents 91% of expected reports from sentinel hospitals.

Yellow Fever Case

In September, 1999, a traveler returning from South America presented to an emergency room in California with a 2-day history of fever, chills, headache, photophobia, diffuse myalgias, joint pains, nausea, vomiting, constipation, upper abdominal discomfort, and general weakness. A diagnosis of **yellow fever** was made at autopsy. This is only the second case of yellow fever identified in a US overseas traveler since 1924.

Basic Epidemiology Series for Nurses

A series of videoconferences focusing on epidemiological principles used in core public health applications is being offered by the OPH Infectious Disease Epidemiology Section. Dr. Susan Hassig, Clinical Assistant Professor of Epidemiology at the Tulane School of Public Health and Tropical Medicine, is the main presenter. Two units have been offered already: Unit 1 - Epidemiologic Terms and Data Sources and Unit 2 - Epidemiologic Rates and Measures. Unit 3 - Epidemiologic Association and Causality, will be held on June 26. These first three units in the first series will be repeated in the fall, pending contract approval.

These series are targeted to OPH nurses, other public health nurses, infection control personnel, and other health care professionals interested in epidemiologic principles and practice. An intermediate series will follow the basic one. The videoconferencing is offered free of charge. Nursing contact hours are awarded; 2.4 for unit 1 and 1.8 for both the 2nd and 3rd units. Participation in each session requires completion of all previous parts in the series for special certification. These videoconferences are accessible at eight sites throughout Louisiana, each connected to the main site at UNO in New Orleans. Using two-way audio and video, participants are able to communicate with the Presenter and the different audiences. Please contact the Infectious Disease Epidemiology Section at (504) 568-5005 for further information.

Online Resources - Infectious Disease Epidemiology Section

The Louisiana Morbidity Report can now be accessed online at the Program's website:

<http://www.dhh.state.la.us/OPH/infectepi/default.htm>.

Issues of this publication dating back to 1997 are available. Also available online are:

1. The Annual Reports for the years 1997 and 1998.
2. Tables of Reported Cases for Louisiana by Year, 1969 - 1998
3. Reported Cases of Selected Diseases by Parish and Health Department Region, 1997 and 1998 (these tables can be accessed individually in an Excel file)
4. Frequently asked questions (FAQs) to the Infectious Disease Epidemiology Section

Plans are underway to include links to other public health resources, and to add additional information as time and resources allow.

The following will be available online in the near future.

1. Guidelines for the Management of Antibiotic-Resistant Pathogens in Health Care Facilities
2. Public Health Infectious Disease Epidemiology Manual, 2000

Outbreak of Gastroenteritis at a Fundraising Event

In March, 2000, the Infectious Disease Epidemiology Section was notified about an outbreak of gastroenteritis among persons attending either a fundraising event, or a wedding reception that took place the next day. At least 430 persons attended one of the events, and at least 60 persons attended both. Approximately 70 people were reported to be ill. No one was hospitalized.

Region V's Rapid Response Team assisted the Infectious Disease Epidemiology Section with designing and distributing a questionnaire to attendees at both functions in order to collect information on symptoms and food history. Telephone interviews were also done. Foodhandlers at both events were interviewed regarding any recent illness and food preparation practices.

Eighty-two questionnaires were obtained. An ill case was defined as any person having reported diarrhea or vomiting. Thirty-four persons met the case definition. Of the 34 ill persons, other reported symptoms were fever (29%), chills (32%), dizziness (15%), and headache (15%; Table 1). The incubation of illness ranged from 23-113 hours, with a mean incubation of 42 hours. The duration of illness ranged from 4-72 hours with a median of 15 hours. People who attended the Saturday fundraiser were more likely to have gotten gastroenteritis than those who did not attend (RR = 3.6). Those who attended the Sunday wedding were less likely to be ill (RR = 0.4). The relationship between illness and foods eaten on both days is shown in Tables 2 and 3, respectively. Those who were ill were far more likely to have eaten potato salad, BBQ chicken, and baked beans than those who were not ill (RR=undefined for these food items). All persons who ate chicken also ate potato salad and baked beans. None of the foodhandlers interviewed reported any symptoms of illness on previous days. Two foodhandlers became ill after eating the meal.

Bacterial culture was negative in the two stool samples obtained. Leftover food samples were not available for either event.

Clinical symptoms of acute gastroenteritis such as diarrhea, vomiting, stomach cramps and low-grade fever, mild - moderate severity and of short duration are characteristic of viral gastroenteritis, most likely a Norwalk-like virus. Norwalk virus is a small RNA virus classified as a *Calicivirus*, and has been implicated as the etiologic agent in about one third of the nonbacterial gastroenteritis outbreaks. The gastroenteritis is usually self-limited, with mild to moderate disease that lasts for about 24-48 hours. Transmission is fecal-oral and associated with contaminated food, and sometimes raw shellfish. Outbreaks are often caused by food contaminated during handling and preparation, such as chopping vegetables and slicing meats. One gram of feces from an infected person contains over one billion particles, and the infectious dose is one virus particle.

Recommendations to prevent this type of outbreak should include: emphasis on handwashing before and after preparation of food items; foodhandlers should be able to recognize gastrointestinal illness and should refrain from handling food for the duration of the illness.

Table 1: Characteristics of Gastrointestinal Illness in Cases (N=34)

Characteristics	No. of cases (%)	No. of respondents
<u>Symptoms</u>	34 (100%)	34
Stomach cramps	12 (35%)	34
Diarrhea	15 (44%)	34
Vomiting	9 (27%)	34
Chills	11 (32%)	34
Fever	10 (29%)	34
Dizziness	5 (15%)	34
Headache	5 (15%)	34

*Case defined as having vomiting or diarrhea between 03/08/00 and 03/15/00.

Table 2: Relative Risk of Illness: Saturday BBQ

Food	Ate		Did not Eat		RR	P value
	Not Case	Not Case	Case	Case		
Saturday BBQ	16	47	1	13	3.56	0.14
Potato Salad	16	41	0	16	Undefined	0.01
BBQ Chicken	16	44	0	3	Undefined	0.30
Baked Beans	16	43	0	14	Undefined	0.02
Sausage	11	31	4	25	1.87	0.39
Oatmeal Pie	11	31	5	25	1.05	0.33
Bread	13	39	3	18	0.92	0.87
W/ice	2	7	13	43	0.96	0.94
Beverage	3	14	12	36	0.71	0.53

*Case defined as having vomiting or diarrhea between 03/08/00 and 03/15/00.

Table 3: Relative Risk of Illness: Sunday Wedding

Food	Ate		Did Not Eat		RR	P-value
	Case	Not Case	Case	Not Case		
Sunday wedding	14	54	3	3	0.41	0.10
W/ice	14	46	3	10	1.01	0.98
Sliced Dill Pickle	11	31	5	25	1.75	0.41
Beverage	14	48	3	9	0.90	0.85
Ice Cream	12	45	5	12	0.72	0.47
BBQ Brisket	14	53	3	4	0.49	0.18
Applesauce	14	52	3	5	0.57	0.30
Potato Chips	14	52	3	5	0.57	0.30
Fruit Pie	12	49	5	8	0.51	0.14
Chicken Sandwich	2	11	15	45	0.62	0.45

*Case defined as having vomiting or diarrhea between 03/08/00 and 03/15/00.

Bulletin

In the fall of 2003, varicella vaccination will be required for all children in child care centers and children entering kindergarten.

HIV/AIDS Update

Response to HIV Treatment in Substance Abusers

Studies have suggested that antiviral treatment for HIV infection may be less effective in persons with mental illness or substance use. To evaluate this in Louisiana, the HIV Program reviewed data from 1,810 patients seen in the HIV Outpatient Clinic in New Orleans during the first six months of 1999.

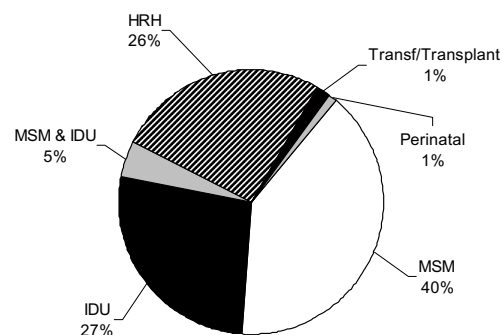
A high percentage of the patients had a clinical diagnosis of mental illness or substance use: 35.9% with depression, 5.9% with anxiety, 5.0% with psychosis, 24.1% with drug use and 14.9% with alcohol abuse. Alcohol abusers were significantly more likely to have had an opportunistic infection (OI) and a detectable viral load (> 400 copies/mL) than those who were not alcohol abusers. After controlling for sex and CD4 cell count, persons with past or active alcohol abuse were more than twice as likely to have an incomplete response to HIV antiviral therapy, as measured by viral load that remained above 400 (odds ratio =2.31; Table). Drug use and the other mental illnesses (depression, anxiety, psychosis) were not associated with incomplete virological response. An unexpected finding was that women were significantly more likely than men to have incomplete virological response. This finding was consistent with other analyses conducted by the Adult Spectrum of Disease Program (ASD) that showed that women were significantly more likely than men to be prescribed a change in the HIV/AIDS Anti-retroviral Therapy (HAART) regimen during the study period and to have depression, a condition that could lead to poorer adherence and incomplete virological response.

There is increasing evidence that HIV-infected persons who have low or undetectable viral load are less likely to spread the infection to others. More work is needed to determine how to increase the success of treatment in alcohol users and women, and clinicians treating HIV-infected patients should be aware that these patients may need more intensive monitoring of the effects of antiviral treatment.

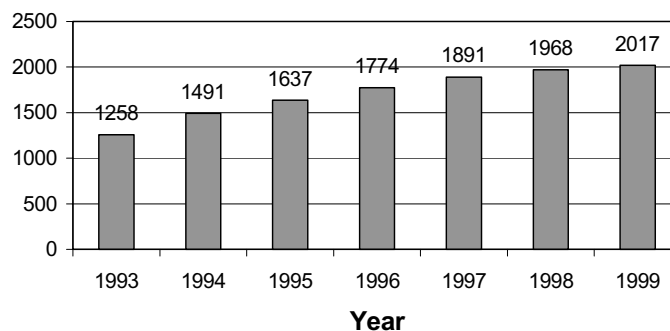
Table: Predictors of Incomplete Virological Response to HIV Antiviral Treatment

	Odds Ratio	95% CI
CD4 Cell Count (<200 vs. ≥ 200)	4.64	(2.92, 7.40)
Alcohol Abuse	2.31	(1.20, 4.44)
Sex (Female vs. Male)	2.00	(1.22, 3.29)

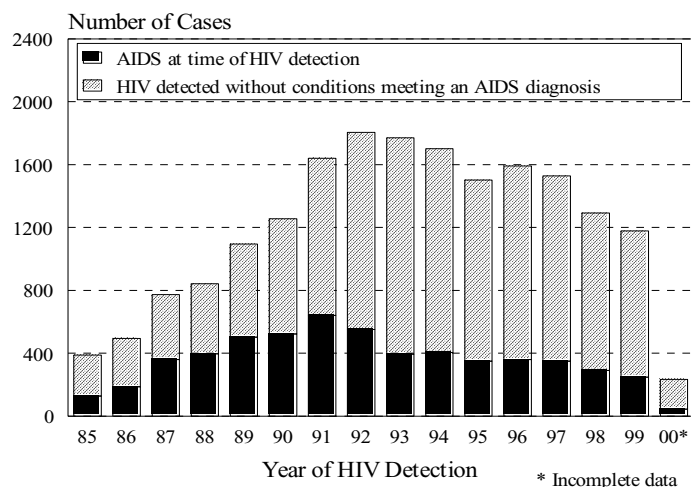
Specified Risk Exposures for HIV/AIDS Cases Diagnosed in Louisiana 1998-1999



Prevalence of IV Drug Use as HIV/AIDS Risk, Louisiana, 1993-1999



HIV/AIDS TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
March - April, 2000
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

HEALTH REGION										TIME PERIOD				
DISEASE	1	2	3	4	5	6	7	8	9	Mar - Apr 2000	Mar - Apr 1999	Jan-Apr Cum 2000	Jan-Apr Cum 1999	% Chg
<u>Vaccine-preventable</u>														
<i>H.influenzae</i> (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	10	2	0	2	0	1	1	1	0	17	34	46	52	-12%
Rate ¹	1.0	0.4	-	0.4	-	0.3	0.2	0.3	-	0.4	0.8	1.1	1.2	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	1	0	0	0	0	0	0	1	2	3	2	50%
Rubella	0	0	0	0	0	0	0	0	0	1	0	1	0	-
Pertussis	0	0	0	0	0	0	0	0	0	3	0	4	3	33%
<u>Sexually-transmitted</u>														
HIV/AIDS Cases ²	49	33	3	9	7	6	8	3	8	126	292	312	581	-46%
Rate ¹	4.7	6.1	0.8	1.8	2.7	1.9	1.6	0.9	2.3	3	6.8	7.2	13.5	
Gonorrhea Cases	593	307	120	164	73	58	468	199	116	2098	2044	4227	4153	2%
Rate ¹	57.1	54	31.8	31.8	27.2	19	92.5	56.7	30.1	49.7	48.4	100.2	98.4	
Syphilis (P&S) Cases	5	6	1	12	4	0	0	3	2	33	43	69	79	-13%
Rate ¹	0.5	1.1	0.3	2.3	1.5	0	0	0.9	0.5	0.8	1	1.6	1.9	
<u>Enteric</u>														
Campylobacter	1	2	1	0	0	3	1	1	2	11	22	28	34	-18%
Hepatitis A Cases	3	2	0	0	1	0	2	0	1	9	18	26	41	-37%
Rate ¹	0.3	0.4	-	-	0.4	-	0.4	-	0.3	0.2	0.4	0.6	1.0	
Salmonella Cases	6	3	2	1	3	3	3	4	4	29	45	69	68	1.5%
Rate ¹	0.6	0.5	0.5	0.2	1.1	1.0	0.6	1.1	1.0	0.7	1	1.6	1.6	
Shigella Cases	8	0	1	2	0	3	1	3	0	19	24	66	42	57%
Rate ¹	0.8	-	0.3	0.4	-	1.0	0.2	0.9	-	0.4	0.6	1.5	1	
Vibrio cholera	2	0	0	0	0	0	0	0	0	2	0	2	0	-
Vibrio, other	0	0	0	1	0	0	0	0	0	1	4	1	4	-75%
<u>Other</u>														
<i>H. influenzae</i> (other)	0	1	0	0	0	1	0	0	0	2	2	6	6	-
<i>N. Meningitidis</i>	2	1	1	0	0	0	2	1	1	8	8	25	27	-7.4%
Tuberculosis	19	6	1	9	1	2	7	12	2	59	47	78	88	-11%

1 = Cases Per 100,000

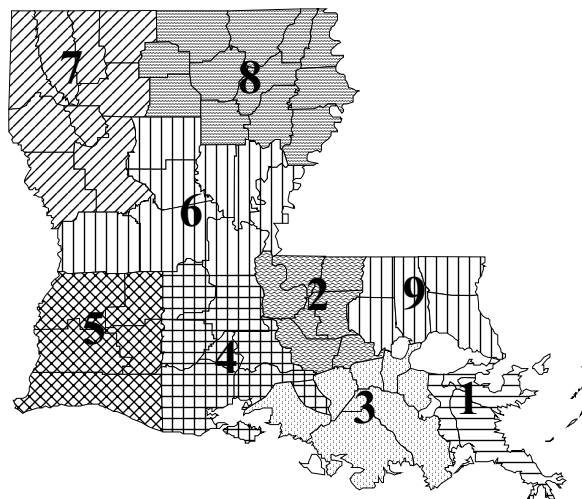
2 = These totals reflect cumulative totals of HIV+ and AIDS cases.

Table 2. Diseases of Low Frequency

Disease	Total to Date
E.coli 0157:H7	1
Lead Toxicity	1
Varicella	63
Legionellosis	4
Lyme Disease	1
Malaria	2
Rabies	3

Table 3. Animal Rabies (March - April, 2000)

Parish	No. Cases	Species
Lafayette	1	Skunk

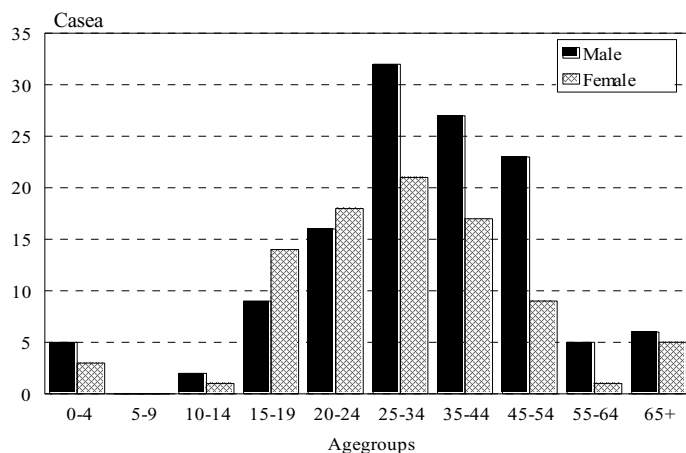


ANNUAL SUMMARY

Hepatitis B - 1998

In 1998, 219 hepatitis B cases were reported in Louisiana, an increase of 5% from 1997. The Louisiana case rate of 5.1 per 100,000 continues to be higher than the 1998 national rate of 3.8 per 100,000. Sex-specific rates continue to be higher among males than females (6.3 vs. 4.0 per 100,000). Race-specific rates were almost six times higher in African Americans than in Caucasians (9.9 vs. 1.7 per 100,000). Sex-race specific rates were highest among African American males (12.0 per 100,000) followed by African American females (8.0). The 20-44 age group accounted for 60% of all reported cases (Figure 1). Of the 40 patients reporting drug use, 2 (5%) used IV drugs during the 6 weeks to 6 months prior to illness. Of the 43 patients reporting contact with someone with hepatitis, 4% had attended child care and 10% had contact with a child care attendee. Of the 37 cases with tattoo information, 6 (16%) reported receiving one or more tattoos 6 weeks to 6 months prior to illness. Thirty-three percent of those reporting number of sexual partners in the six months prior to infection had greater than two sexual partners. Eighty-eight percent of the cases reporting a sexual preference were heterosexual. Parishes reporting the highest case rates per 100,000 included Tangipahoa (17), West Feliciana (15), Pointe Coupee (13), Orleans and Washington (12), and St. Charles (11) (Figure 2).

Figure 1: Cases of hepatitis B in Louisiana by sex and age group, 1998



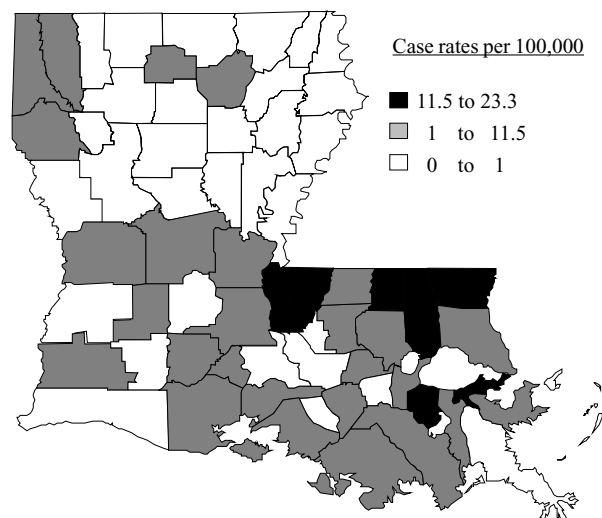
In 1998 the Louisiana Perinatal Hepatitis B Program reported that 64,864 pregnant women were screened statewide for HbsAg and that 203 (0.3%) of these women were positive for HbsAg. From these 203 HbsAg positive women identified, 110 live births were followed and 97 (88%) of these babies completed the series of HBIG and hepatitis B vaccine.

While there is no cure for hepatitis B, it can be prevented. Immunization with hepatitis B vaccine is the most effective means of preventing HBV infection and its consequences. The vaccine is administered in 3 doses, the initial dose, followed by a dose at one month and a final dose at six months. The vaccine is recommended for all babies beginning at birth, adolescents, persons whose occupation expose them to human blood, people who live in the same

household or have sexual contact with someone who has lifelong hepatitis B virus infection, people who have sex with more than one partner, intravenous drug users, hemophiliacs, patients or staff of institutions for the developmentally disabled, and those who travel internationally to areas with a high prevalence of hepatitis B virus.

Since the 20-44 year age groups had the highest number of cases of hepatitis B, physicians are encouraged to assess risk information and to consider immunizing whenever a patient comes in for a routine office visit. Also, risk factor information can be given to the patient-at-risk at each office visit.

Figure 2: Rates of hepatitis B by parish, 1998



Louisiana Fact

In 1901 an anti-mosquito campaign was inaugurated by the Health Officer of the city of New Orleans. A circular was printed in local newspapers explaining why a drive was being organized to rid New Orleans of *Stegomyia fasciata* and anophelines (malaria transmitter) mosquitoes. Householders were asked to follow recommended procedures designed to destroy larvae and prevent depositing of eggs upon the surface of breeding places. Among the more important recommendations were:

First - Once a week pour into every cistern or tank containing water eight ounces of refined paraffin oil or two ounces of kerosene oil, paraffin oil being preferred.

Second - Once a week pour upon every pool of stagnant water and every water surface on your premises, not removable by drainage or stocked with fish, a quantity of kerosene or of crude petroleum, equivalent to one ounce for each fifteen square feet of water surface.

The New Orleans Board of Health undertook the work of mosquito proofing cisterns and street gutters in selected localities. Unfortunately the program had to be abandoned before long; unappreciative householders undermined an effort which could succeed only with nearly total cooperation.

Source: *The Progressive Years*, by Gordon E. Gillson.

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES			OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection ³	Shigellosis	Severe traumatic head injury**
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Lead Poisoning
Chlamydial infection ²	Malaria	Tetanus	Phenylketonuria*
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical ⁴	Vibrio infections (excluding cholera) ¹	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection ¹		Sudden infant death syndrome (SIDS)
Gonorrhea ²	Pertussis		
Haemophilus influenzae infection ¹	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

¹ Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

² Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

³ Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

⁴ Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with *'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

* Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

** Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

Numbers for reporting communicable diseases

1-800-256-2748

Local # 568-5005

FAX # 504-568-5006

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